Attachment A. I.
to Family Care Waiver
Application Pre-Print

Section A:
Program Impact

Background

What is the Purpose of Redesigning Wisconsin's Long Term Care System and Seeking a 1915(b)/(c) Combination Family Care Waiver?

For many years Wisconsin built its long term care (LTC) system around its substantial network of nursing facilities and its nationally recognized Community Options Program. Over the years, HCBS waivers and other programs were added piecemeal. The result was less a system than a loose aggregation of programs and services for people with LTC needs, many of which had different eligibility requirements and other rules, frequently in contradiction to each other. The most notable disconnect in the system was providing sum-sufficient funding for independently-owned nursing homes, but limited block grants to county governments for community-based services, causing waiting lists for the most appropriate, affordable and desired options. This system design flaw resulted in an incentive for community providers to shift participants to nursing homes when their services became too complex or costly, perpetuating over-reliance on expensive nursing home care.

Recognizing this problem and faced with a rapidly growing population in need of long term care, Wisconsin began a major effort in 1995 to completely overhaul its LTC system. The goal was to align system incentives to ensure that individuals would be provided comprehensive long term care and support that maximizes independence, recovery and quality of life, with meaningful choices of supports, services, providers, and residential settings, as long as such care or support is necessary, meets an adequate level of quality, is cost-effective, is consistent with the individual's values and preferences, and can be provided within available resources.

In more practical common sense terms, consumers, advocates and providers told us their goal was to have a system that is:

More Responsive—

- Gives people better choices about where they live and what kinds of services and supports they get to meet their needs. Lets them manage their own services to the degree that they are willing and able.
- Organizes services and money around individuals, not around service types. Case managers help each enrollee develop a personalized plan of supports that fits his or her needs, circumstances and preferences.
- Lets people who want to work do so, getting the support they need while paying what they can for health and long-term care.
- Keeps fee-for-service Medicaid State Plan services intact as an option for those who choose not to enroll.
- Makes sure people know about their choices when they are making critical long-term care decisions—particularly when they are seeking admission to a nursing home or other residential facility.
- Gives people some help before they become impoverished, but requires everybody to contribute what they can to the cost of their care.

More Reliable and Fair?

- Guarantees access to those with the highest needs and those already receiving nursing home or county-managed community services.
- Creates Care Management Organizations that receive funding for every eligible person who chooses to enroll. Provides funding up front, in a per person per month payment, rather than in a fixed block grant.
- Allows funds to be used flexibly for everything from sidewalk shoveling to nursing, with in-home and residential options available to everyone who enrolls, and nursing home options available to everyone who meets level of care.
- Lets funding follow each person across service settings, county lines and time.
- Protects consumers' safety and rights.
- Assures that access, choice and quality are consistent from county to county.

More Understandable—

- Develops "one-stop shopping" through Aging and Disability Resource Centers, where everybody can learn about community resources and government programs and get unbiased, professional advice about their options.
- Has fewer rules and fewer cracks to fall through. For those who choose to participate, collapses multiple programs and fragmented delivery systems—including Medicaid fee-for-service funds—into one funding stream.

Accountable?

- Manages for quality. Measures performance based on how well people who are elderly or disabled do, not on how many units of service were provided.
- Instead of county mandates, lets counties choose whether or not they want to participate in managing the new system.
- Transfers management tools to local care management organizations and holds them accountable for managing all long-term care resources for their enrollees.
- Involves consumers in system design and direction at State and local levels.

Affordable Now and into the Future?

- Uses existing resources more efficiently and effectively. On average, Wisconsin spends 50% more than the national average for each Medicaid-eligible elderly person. Wisconsin currently spends $1.5 billion, about 8% of the total State budget, on long-term care, and by 2040, the over 65 population will double, the over 85 group triple.
- Eliminates the institutional bias and allows public funding to support the most cost-effective setting for each person.
- Helps people stay as independent as possible. Incorporates prevention efforts to avoid or postpone the need for long-term care. Provides ready advice that can help people make their own resources last longer.
- Helps individuals and families identify community resources. Provides just the right amount and kind of paid services and supports in the right place, at the right time.
- Reduces our reliance on services that are more medical, professional and/or restrictive than people want or need. Given real choices, people usually choose less formal and less expensive supports to meet their needs.

How Will Services be Accessed in the Redesigned System?

Resource Centers – I & A, Options Counseling and Access to Long Term Care

All of the stakeholders involved in establishing the high level goals and objectives of LTC redesign were strongly supportive of a single local entry point, or "Resource Center," for long term care and related services. In the current system consumers are often forced to "shop" for needed information and support among a confusing conglomeration of programs, providers and services without knowing what's available, where to get it, and how much it will cost. Consumers were adamant that Resource Centers must be able to provide "one-stop shopping" where everything an individual needs to know about LTC and how to access it are available without being shunted from one program to another, one provider to another, or one person to another.

Resource Center responsibilities are much broader than merely providing access to the Family Care waivers or services. Aging and Disability Resource Centers are intended to become well-known local places where members of the community understand that they can get information about issues and resources that are important to elders and persons with disabilities. This includes, but is not limited to information and resources related to long term care, available local services and providers, how individuals can obtain needed services and whether public assistance is available to them.

Stakeholders involved in redesigning Wisconsin's long term care system felt strongly that one of the key components of Aging and Disability Resource Centers must be community education and outreach. People should be able to access information and assistance and good advice about long term care before they are in crisis. In fact, being able to access this long term care options counseling is a key component in prevention and early intervention. By providing timely information and advice, Resource Centers can help prevent or delay the need for acute care that frequently results from chronic health conditions (e.g., bed sores, over-medication), and by helping to maintain health and independence, delay the need for more intensive long term care services. Making options counseling available to the community as a whole, including to people who are not yet eligible, whether functionally or financially, can also delay the need for publicly-funded services by helping them access generic community resources and use their own financial resources most wisely.

Functional assessment is usually a key component of options counseling. It is difficult to provide the most useful information, targeted to the individual's specific needs and circumstances, without an understanding of that person's level of functioning. Resource Centers have also discovered that, especially for elders, it is necessary to develop a relationship – to get to know individuals and give them time to get to know you -- before asking the intimate and personal questions that must be asked in order to assess their level of functioning.

This options counseling is different than enrollment choice counseling. Options counseling is the process of helping people begin to explore the broad range of long term care programs, services and service delivery systems, and to begin the process of getting to know them in order to better assess which they might be eligible for and the options that are available and might

potentially meet their needs. Enrollment choice counseling is designed to help people who have already been determined to be eligible to select the service delivery model that would be most appropriate for them – traditional fee-for-service or managed care. And if they choose managed care, to receive appropriate comparative information to help them select the managed care entity that might best meet their needs.

The State recognizes that access to services and service systems is an area where there is potential for conflict of interest. The State intends to carefully monitor options counseling services in Resource Centers to ensure that it is not used to "steer" individuals towards or away from any particular program, service or service delivery system prior to having the benefit of enrollment choice counseling. The topic of conflict of interest is discussed more fully in a later section.

Eligibility for Family Care and Entitlement to Immediate Services

To be eligible for Family Care an individual must:

- Reside in a county where Family Care is being piloted.
- Be at least 18 years of age.
- Have a physical disability, developmental disability or infirmities of aging.
- Be functionally eligible for Family Care:
  1. At the comprehensive level – the person has a long term or irreversible condition and requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screen:
     a) The person cannot safely or appropriately perform:
        - 3 or more activities of daily living.
        - Two or more ADLs and one or more instrumental activities of daily living.
        - Five or more IADLs.
        - One or more ADL and 3 or more IADLs and has cognitive impairment.
        - Four or more IADLs and has cognitive impairment.

     b) The person:
        - Requires frequent medical or social intervention to safely maintain an acceptable health or developmental status; or requires frequent changes in service due to intermittent or unpredictable changes in his or her condition; or requires a range of medical or social interventions due to a multiplicity of conditions; and
        - Has a developmental disability that requires specialized services; or has impaired cognition exhibited by memory deficits or disorientation to person, place or time; or has impaired decision making ability exhibited by wandering, physical abuse of self or others, self neglect or resistance to needed care.
  2. At the intermediate level – the person has a long term or irreversible condition and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others, as is evidenced by a finding from application of the functional screen that the person needs assistance to safely or appropriately perform either of the following:
     a) One or more ADL, or
     b) One or more of the following critical IADLs: management of medications and treatments, meal preparation and nutrition, or money management.

3. Or be grandfathered in for Family Care functional eligibility – the person:
   a) Has a long–term or irreversible condition.
   b) Is in need of services included in the Family Care benefit.
   c) On the date that the family care benefit became available in the county of the person's residence:
      - Was a resident in a nursing home, or
      - Had been receiving for at least 60 days, under a written plan of care, long term care services under any of the following:
        - Any Medicaid home and community-based waiver program.
        - The State-funded Community Options Program.
        - The State-funded Alzheimer's Family Caregiver Support Program .
        - Services provided through State- and county-funded Community Aids.
        - Services provided through county funding.

- Be financially eligible for Family Care by:
  1. Being financially eligible for MA, or
  2. Having case plan costs that exceed her/his gross monthly income plus one–twelfth of his/her countable assets, less deductions and allowances permitted by rule by DHFS (see attached Family Care Administrative Rules Chapter HFS 10).

Some, bur not all, individuals who are eligible for Family Care will be eligible for Medical Assistance either through regular MA eligibility or expanded waiver eligibility. No federal financial participation will be claimed for Family Care services provided to individuals who are Family Care-eligible but not Medicaid-eligible.

To be entitled to Family Care services without being placed on a waiting list an individual must meet one of the following:

- Be eligible at the Family Care comprehensive functional level.
- Be eligible at the Family Care intermediate functional level and:
  1) Eligible for Medical Assistance, or
  2) In need of protective services.
- Be grandfathered in for Family Care functional eligibility.

The Wisconsin Long Term Care Functional Screen Determines Functional Eligibility

Eligibility for Medical Assistance, and whether an individual is eligible for and entitled to Family Care is determined in the Resource Center. The tool used to assess level of care for both the waivers and for Family Care is the Wisconsin Long Term Care Functional Screen (LTCFS). This is an automated tool for capturing objective information needed to determine whether an individual is eligible for institutional care reimbursable by Medicaid, and whether an individual meets the intermediate or comprehensive Family Care level of care.
The LTCFS is a reliable and valid tool that results in level of care determinations that are highly congruent with determinations through the Bureau of Quality Assurance level of care process used to determine level of care for admission to a nursing home, and does so consistently among different screeners. HCFA has already approved use of the functional screen in place of the BQA process. (See Attachment 2 to the document "Protecting against Conflict of Interest" which is included at the end of this attachment.)

The LTC FS has undergone over three years of revisions that incorporated inter-rater reliability tests, validity studies, and on-going input from screeners and others (researchers, advocates, etc.). Screen development and revisions were based on criteria of clarity for users (all questions must be clear to users), brevity, inclusiveness ((i.e., every unique individual can be accurately described with choices provided for each question), validity in determining nursing home level of care (hence waiver eligibility) and Family Care functional eligibility, and objectivity.

The objectivity exists at two levels. First, each question and its limited multiple choice answers must be precisely worded so as not to be open to varying (subjective) interpretations. Second, selection of the most accurate answer must be objective in the sense that all screeners would answer similarly. Both aspects of objectivity have been improved through extensive on-going contact with screeners. Literally hundreds of screeners' comments and questions have been accrued since 1998. All have resulted in screen refinements and/or been incorporated into screen instructions and trainings. The LTCFS exceeds industry standards. See Screen Instructions pages 4 – 6 in Attachment 2 to the document "Protecting against Conflict of Interest" which is included at the end of this attachment regarding generally recognized problems with any functional assessment tool.)

For instance, for activities of daily living, screeners have only three choices to indicate the level of help the consumer needs. "Help" is defined as participation (supervision, cueing, or partial or complete hands-on help) needed from another person. The notion of "needs" is complex and is discussed throughout instructions and trainings. (For instance, what if the person needs help but is not getting it? What if they're getting it but don't really need it? What if they or their family deny or exaggerate a need?) Screeners are guided as precisely as possible to reduce subjective interpretations. The choices for level of help needed are fairly simple and direct, again reducing subjectivity. Either the consumer can do the task without help, or the helper does not need to be present throughout the task (e.g., lay out clothes, help into and out of bathtub but can leave consumer sitting in tub unattended), or the helper must be present throughout the task. Room for subjective interpretation has been minimized.

The instrumental activities of daily living (meal preparation, money management, management of medications and treatments, transportation, employment, use of telephone) require more task-specific answer choices. Those choices, too, have been revised for greater inter-rater reliability (i.e., objectivity). Most of the answer choices reflect the frequency at which help is needed from another person, e.g., monthly, weekly, or daily, or continuously. Frequency of interventions actually needed is a more objective measure than adjectival descriptions (e.g., "stable," "unstable," "severe") that are found on many other functional needs assessments.
One of the greatest challenges in designing objective functional assessments involves screeners' opinions about safety. Standards of safety can be very subjective and can reflect class and cultural biases. One solution has been the development of a "risk module" in which screeners can note their concerns about safety and risk factors. This serves as a "release valve" for screeners to express their opinions while more accurately describing the person's actual needs.

The few questions on the screen that do allow for more professional judgment (and perhaps subjectivity) are informational only, and do not play a role in eligibility determination. These include questions on substance abuse, mental illness, and risk factors.

Unlike many other states' waiver eligibility tools, in order to enhance objectivity the screen was purposefully not constructed as an "in-out" checklist or numerical scorecard. In those approaches, descriptions are checked to directly create eligibility results, and the screener's role (conscious or not) tends to become one of exploiting the tool – checking the right boxes to get the desired result. The Wisconsin LTC functional screen computer logic is weighted in multiple functional areas to assess both the frequency and intensity of assistance needed by consumers. This approach in which the eligibility logic is complex and not evident in the screen itself helps to refocus the screener's role to describing needs rather than exploiting a bureaucratic form. The screener's task in helping people access programs and services becomes simply to tell the truth – to answer each question as accurately as possible to describe the person's actual needs.

Of course some screeners may still try to answer questions in order to make ineligible people appear eligible. But the State is confident that the refinement of individual data elements on the screen to enhance clarity and objectivity, and eliminate subjectivity will discourage such actions. Training and instructions for screeners have emphasized that the Department will be able to identify inaccurate entries, which because the questions call for very objective responses, will be very difficult for a screener to explain away as innocent misinterpretation or misunderstanding.

The importance of verification of health-related services, diagnoses, and target group questions is strongly emphasized in screens trainings and instructions. (Screener training and certification is a requirement of the Resource Center contract). Screeners are instructed to contact (with the consumer's permission) health care professionals familiar with the person being screened. To facilitate rapid eligibility determination for consumers, screeners have been instructed to call or fax the person's primary care provider(s) and/or any home health agency or personal care agency nurse involved in the person's care.

We have found that even such consultation with health care providers does not ensure an accurate assessment of the person's actual needs, particularly in community settings. Many health care professionals' descriptions of needs reflect reimbursement and regulatory constraints and habits more than an individual's actual needs, and may reflect physician's lack of awareness of how people manage at home. Since most screeners are social workers, we have found through experience that it is imperative that Resource Centers have nurses available for consultations, either on staff or through contract. Nurses are better able to accurately interpret medical records to determine the individual's actual needs in the context of what other health care professionals say.

For example, a screener was told by a physician and a home health agency nurse that a 67 year old man did not need help with medication management. Yet he'd been hospitalized the previous month for lithium toxicity, dehydration, electrolyte imbalances, and psychosis (after police found him wandering naked in the street). He had serious mental illness, had not been taking his medications for some time, and had cognitive impairment. The screener needed a nurse who could discern that the health care providers meant that this man would not be eligible for Medicare-funded in-home medication management because he was not homebound. The nurse was able to follow up to procure a more accurate description of the man's real needs for the functional screen. Such accuracy is particularly important in the screen's "health-related services table," which affects the nursing home level of care.

The State will monitor closely the performance of each agency contracting for level of care assessment. (See the section, "How Will the State Protect against Conflict of Interest" below for a description of quality assurance plans.)

Economic Support staff co-located in the Resource Center will determine financial eligibility for Medical Assistance, and for persons not MA-eligible will determine non-MA eligibility for Family Care. They will also determine the amount of any cost sharing for which the potential enrollee will be liable.

Special Access Features

Independent enrollment counseling: Wisconsin will contract for enrollment counseling with an entity that is independent of any county, Resource Center, CMO or other service provider in the State. This will ensure that consumers receive unbiased information about the relative benefits and drawbacks of enrolling in managed care or receiving services from fee-for-service providers, and the relative merits of the different managed care organizations available.

Independent advocacy services: Wisconsin has contracted with an independent entity to provide enrollees and potential enrollees with advocacy services. While each CMO is required to have an internal consumer advocate, the stakeholders involved in the redesign of Wisconsin's long term care system felt strongly that consumers would need help in coping in the managed care environment. This service is funded at a level that provides local/regional advocates at a rate if one advocate for every 1,000 enrollees. Goals of the independent advocacy service are to:

- Facilitate access to appropriate use of long term care services in the Family Care Pilot counties through the provision of individual case advocacy services.
- Improve access for potential Family Care enrollees through the provision of information, technical assistance, and training to individuals and local long term care councils about how to obtain needed long term care services and support.
- Enhance the capacity of Family Care to foster consumer independence, consumer knowledge and dignity, and to protect consumers through the provision of individual consumer advocacy.
- Increase the capacity of consumers and family members to be self-advocates within the Family Care system.

Among the kinds of case specific assistance the independent advocacy service can provide to enrollees and potential enrollees are:

- Determination of eligibility, entitlement or cost sharing.
- CMO development of a plan of care that is unacceptable to the consumer.
- Failure of a CMO to provide timely services and support items in the plan of care.
- Reduction of services or support items.
- Termination of the Family Care benefit.

How Will Services be Delivered in the Redesigned System?

Through a prepaid health plan (PHP) for some current Medicaid State Plan services including nursing home care, and a 1915(b)/(c) combination waiver, Wisconsin is proposing to transform

its publicly-funded LTC system into one in which the goals of Wisconsin's long term care redesign effort can be achieved. Local Care Management Organizations (CMOs) will receive a capitated, prepaid monthly payment for every eligible person who chooses to enroll, and will be responsible for each enrollee's long term care, whether that care is provided in-home, in an alternative residential living arrangement, or in a nursing home. Without the ability to disenroll a person and shift costs to another provider or system, the CMO's incentive is to provide the most appropriate care and services to each individual in order to help enrollees maintain their health and remain as independent as possible. For providers, inflexible authorization rules and incentives to provide the services the system would pay for rather than the optimal service to meet each individual consumer's needs are eliminated. The State believes that realigning incentives in the system will allow it to make long term care an entitlement for every eligible individual and eliminate waiting lists for community-based services.

CMOs will conduct a comprehensive assessment and develop an individualized service plan that is tailored to each enrollee's unique needs, circumstances and preferences. All needed waiver and other Family Care services are identified in that plan. The CMO assists each enrollee in locating, coordinating, and monitoring all of the services in the Family Care benefit package that are identified as needed in the enrollee's individualized service plan. The CMO's interdisciplinary case management team will assist the member in gaining access to all needed LTC services, and will help coordinate them with other supports and services, including health care services, the enrollee receives. The interdisciplinary team will monitor the member's condition, health care needs, and services on an ongoing basis.

How Will the State Protect Against Conflict of Interest

Independent enrollment counseling

As described earlier, under "Special Access Features," in order to ensure that consumers have unbiased information to make informed choices, the State will contract for enrollment choice counseling with an entity that is independent of any county, Resource Center, CMO or other service provider.

State Quality Assurance Monitoring of Critical Resource Center Functions

Eligibility determination: The State plan for monitoring the quality of level of care assessment within the Resource Center includes using and monitoring the use of an objective automated functional screen, including:

- Providing an instructional functional screen manual to each contracting agency.
- Providing functional screen bulletins as needed to communicate general information and policy, changes in procedures or protocols, and quality improvement strategies.
- Maintaining a functional screen hot line to answer screener and screen lead questions.
- Creating and maintaining programmed data entry-level quality features, including:
  1) Edits within the screen application that disallow omissions of mandatory fields.
  2) "Completion matching" to call up and categorize diagnoses when initial letters are entered (to reduce misspellings and redundancies).

3) Automatically limiting items that may be selected for particular questions based on responses to earlier entries.
4) Additional programmed data-entry level edits for quality assurance based on complex clinical logic overlying all screen modules, which cue the user in response to screen entries that appear to be incoherent (e.g., person with significant cognitive deficits marked as independent with medication monitoring). Pop-up cues explain the apparent discrepancy and suggest local quality assurance follow-up activities. Incoherent entries must either be corrected, or an explanation must be provided in the "Comment" field. Such screens will be marked for further follow-up by the Department after screens have been submitted to the data warehouse.

- Regularly performing analytical queries on completed screens to seek out suspected quality problems. This will include a complex clinical logic that can seek out incoherencies or any other target issue desired.
- Conducting routine statistical analyses of completed screens to compare level of care assessments for each individual contract agency with statewide data, comparing both the level of care awarded for individuals with like diagnoses and/or functional deficits, and the incidence of reporting of selected functional deficits that have a significant impact of the level of care awarded (e.g., assistance with bathing).
- Conducting routine comparisons of deficits reported on individuals' functional screens with the CMO assessments, care plans and service encounters for those individuals.
- State staff conducting annual quality assurance site reviews of all Resource Centers.
- State staff (e.g., Regional CIS and AA Team staff) auditing for the accuracy of functional screens submitted by each Resource Center, including:
  1) Regular periodic checking of functional screens (e.g., quarterly to begin, with frequency increasing or decreasing based on the level of verified accuracy).
  2) Selecting a statistically valid random sample of persons who have received screens that is representative of all of the Family Care target groups served by that Resource Center (again sample size may be increased or decreased based on the level of verified accuracy).
  3) Interviewing the persons screened to verify the accuracy of each screen field entry.
  4) Determining whether any inaccuracies discovered would have resulted in the automated functional screen logic awarding a level of care inappropriately.
  5) Identifying any patterns in the type or amount of inaccurate entries and providing feedback, technical assistance and, if necessary, taking other contract monitoring actions identified below.
- Implementing a contract monitoring system to take corrective action whenever monitoring and quality assurance efforts discover problems or discrepancies, including:
  1) Plans of correction.
  2) Fiscal sanctions.
  3) Termination of county contract; enter contract with independent entity.

Options counseling – Options Counseling is the process whereby potential long term care consumers are introduced to and informed about the range of resources available in the community for all types and levels of long term care, and the steps needed to access these different options. Options counseling provided by the Resource Center is very high level counseling, with the Resource Center staff describing the broad array of resources available in

the region to fit a person's needs. It is different from enrollment choice counseling activities which are much more specific, are received at the end of the eligibility process and have to do with assuring a potential customer's informed understanding and consent when joining a health care delivery system governed by managed care principles. This may include arranging for a functional screen assessment and linking the person to the financial eligibility team.

The State will monitor the quality of options counseling at the Resource Center in order to prevent "steering" of individuals early on in the process of accessing services. The approach to State quality assurance monitoring includes

- To meet contract requirements, a Resource Center must have fully trained staff skilled in communication and interviewing, with knowledge of the target groups with which the Resource Center will be doing options counseling. These individuals will also provide long term care options counseling for persons seeking admission to residential care facilities, provide information and assistance and options counseling to individuals referred or self-referred from the community, and perform the long term care functional screen to determine functional eligibility for long term care programs including Family Care.

- Staff receive Options Counseling training from both the Resource Center on local resources available. And the State provides training regarding approved Options Counseling materials and their presentation. This training is interactive and given by the staff of the Center for Delivery Systems Development in conjunction with the Department program bureaus and in compliance with HCFA regulations governing managed care programs. The curriculum includes: function of a Resource Center, scope of information to be covered, assessment interviewing techniques, and communication skills.

- As part of local quality assurance, each Resource Center is required by contract to conduct random surveys of Resource Center callers, asking a series of satisfaction questions, including questions about the Options Counseling and whether the information received was useful and unbiased.

- The Department assesses the effectiveness, scope and neutrality of high level options counseling at the quality site visit for Resource Centers, which occurs semi-annually in the first contract year and annually thereafter. These site visits involve a team from the Department that reviews the quality of services delivered by the Resource Center and reports back to the Resource Center indicating the areas where the Resource Center needs any of the following: technical assistance, a plan of correction or a local quality initiative.

- The Department also receives data on Resource Center contact types on a quarterly basis. The results of contacts are analyzed and potential problems can be identified when a particular Resource Center does not appear to be broad enough in it's approach to options counseling. Current data indicates that with the nine current pilots, of 35,415 contacts by individuals to Resource Centers in December 2000, only 23% were calls for information related to LTC services, 25% were calls related to seeking Wisconsin Medicaid and food stamps. This is the balance the Department would expect to see in terms of the broader definition of Options Counseling.

Allowing for local structural variations

The State intends to allow local entities undertaking Family Care pilots to design the process of eligibility determination to fit local government structures. This could include creating a Family Care District to operate either the Resource Center or CMO, co-locating county Economic Support Workers (who determine MA eligibility in the current system) within the Resource Center for Family Care eligibility determination, and allowing Resource Centers to directly employ staff to do eligibility determination.

Independent advocacy services

The independent advocacy services described in more detail in the section on access will also serve as an additional set of eyes and ears to help the State protect against conflict of interest.

Will There Be a "Down-Side" to the Redesigned System for Consumers?

No. Acute and primary health care services, which are carved out of the Family Care benefit, will be provided under the Medicaid State Plan. Family Care enrollees can continue to choose any willing provider. The interdisciplinary team in the CMO is responsible for coordinating long term care supports and services with acute and primary services furnished by the enrollee's fee-for-service health care providers.

While the 1915(b) waiver Wisconsin is requesting does require that individuals who want waiver services get them through the Family Care (managed care) program, the Family Care 1915(c) waivers include all of the services in Wisconsin's existing HCBS waivers. And since those existing waivers do not offer full freedom of choice of providers, restricting choice of waiver providers to those in a CMO's network is not really more restrictive than the current programs.

The services in the Family Care benefit that were Medicaid State Plan services will be available to Family Care enrollees only through a PHP contract between the State and the CMO, and hence the providers in the CMO network. This is viewed by the State, CMOs and consumers less as restricting consumers' freedom of choice of provider than as removing the standard Medicaid requirement for any willing provider in order to ensure that CMOs can contract for the highest quality services with the most effective and efficient service providers. The CMO provider network is required to have adequate capacity, choice, geographic diversity, cultural competency, and ability to meet diverse needs.

Minimum provider standards for all CMOs in Family Care assure quality and consumer choice among providers. Each CMO must obtain certification prior to contracting to receive reimbursement. The certification process includes a thorough review of the provider network to assure there is adequate choice of providers for services in the benefit package. Providers must be certified Medical Assistance providers or meet standards approved by the State. The provider network is reviewed at least annually to determine whether the CMO continues to meet minimum standards and to determine capacity of the CMO to serve new enrollees. If the network is not adequate the State may impose enrollment suspensions or limitations until deficiencies are cured or the State may arrange for services directly and deduct the cost of such services from payment to the CMO.

In addition to assuring quality and choice within the provider network, the CMO must purchase services from any qualified provider selected by the member for intimate and personal services or for services requiring frequent access to the member's home. If a member identifies a willing provider that is not a part of the provider network it is the responsibility of the CMO to determine whether the provider or individual meets the provider standards for the CMO and contract with the member-selected provider. A member may also use a non-CMO provider if the CMO approves a member's request in advance. Requests must be approved if the CMO network lacks the capacity to meet the member's need, lacks the expertise or skills necessary to meet the need, lacks the ability to meet the need in a timely manner, or lack of transportation limits the member's ability to use a CMO provider.

How Have Consumers Been Involved in Redesigning LTC in Wisconsin?

The Wisconsin Department of Health and Family Services launched the Long Term Care Redesign project in November of 1995. Activity over the next year and a half included the following:

- A Long Term Care Redesign Advisory Committee consisting of consumers, advocates and providers to assist in establishing high level goals and objectives for redesigning the system.
- Three Steering Committees with broad representation, including consumers and their representatives, which assisted the Department in developing LTC Redesign goals and objectives consistent with the needs of the Family Care target groups:
  - Steering Committee on Aging and Chronic Conditions.
  - Steering Committee on Developmental Disabilities.
  - Steering Committee on Physical Disabilities
- A series of focus groups with elderly and disabled LTC consumers held in a variety of service settings and geographic locations. These focus groups also assisted in defining what was wrong with the current LTC system and how it could be improved.
- A LTC Redesign Team composed of middle and upper level managers across the broad spectrum of LTC responsibilities of DHFS. The Redesign Team met at least weekly for over a year.
- A number of work groups composed of DHFS staff who gathered and analyzed information, prepared issue papers, and made recommendations to the Redesign Team.
- A LTC Redesign Executive Committee composed of senior DHFS managers, including the Department Secretary, who made final system redesign decisions.

In May 1997, the Department released its preliminary proposal for LTC Redesign and scheduled a series of public hearings. Response to the proposal was mixed. Although many expressed agreement with much of the proposal, there was considerable concern about several issues. In response to these concerns, the Department announced that it would reconsider these issues and rework the proposal.

From July to January, top Department staff met individually with a number of stakeholders to discuss their specific concerns. In October of 1997, Secretary Leean announced that the Department had modified its position on several issues that had been the focus of concern. He also announced the creation of the LTC Redesign Consolidated Steering Committee to assist in resolving remaining areas of disagreement among major stakeholders. This Committee included all major stakeholders, including consumers, family members, consumer advocates, in-home, community and institutional service providers, counties and tribes.

The Consolidated Steering Committee held its first meeting on October 24, 1997. Members expressed a strong desire to work together to resolve remaining differences. They agreed to the creation of smaller work groups to work on specific issue areas. These work groups met between December 1997 and March 1998, developing consensus around a number of issues. Each of the work groups included membership from all stakeholder groups, including consumers.
In his January 1998 State of the State address, Governor Thompson proposed the creation of "Family Care," his name for the effort to reform Wisconsin's LTC system, and directed the Department to develop legislative language for inclusion in its biennial budget request. The Department developed a revised proposal, based on the recommendations of the work groups and the Consolidated Steering Committee; on issues where consensus had not been reached, the Department made proposals that reflected the input received. The LTC Redesign Consolidated Steering Committee discussed this revised draft proposal at its meeting on April 17, 1998. In May, the Department published a further refined draft that incorporated many suggestions from the Steering Committee.

Nine consumer forums were convened between May and August 1998, to discuss the Department of Health and Family Services draft proposal of the Long Term Care Redesign effort. The forums were attended by more than 2,000 consumers around the State. Held in Milwaukee, Madison, Green Bay, Eau Claire, Racine, La Crosse, Superior, Wausau, and Dodgeville, these forums were part of an ongoing effort to educate consumers and citizens about proposed changes in Wisconsin's provision of long term care and support, answer their questions, and obtain their input and suggestions. This consumer input was reflected in the Department's LTC revised redesign proposal submitted during the summer of 1998.

As directed by the Governor and the Legislature, the Department submitted drafting instructions to the Legislative Reference Bureau and issued a further refined proposal for Family Care on July 31, 1998. Governor Thompson included the Family Care proposal in his 1999-2001 biennial budget request. During the legislative process, further amendments were negotiated to respond to remaining concerns of consumers and advocates. Several thousand older people and people with disabilities demonstrated at the Capitol in May of 1999 in support of the Family Care legislation. Family Care legislation was enacted as part of the biennial budget in early October 1999 (1999 Wisconsin Act 9).

Family Care Waivers

The Family Care legislation directs the Department of Health and Family Services to seek whatever Medicaid or other federal waivers necessary to implement and forward the goals of the Family Care program ? to use existing LTC resources more effectively and efficiently to improve public awareness of and access to LTC services, provide each eligible person with high quality LTC services tailored to his or her unique circumstances and preferences, and to improve service coordination and enhance continuity of all of the services and supports needed by the Family Care target groups.

The legislation also specifies that during the Family Care demonstration phase, to be a certified CMO, the organization must be a county or tribal agency. Therefore, during the initial waiver period, the State has sought and received approval to operate the Family Care PHP and HCBS

waivers under a sole source contract with each county or tribal agency selected. The sole source agreement calls for competition to be phased in during the first calendar year following the initial waiver period. However, the State may contract with competing organizations a year sooner than that if necessary to ensure that there is adequate capacity and quality of Family Care services in a Family Care demonstration county.

Each CMO will be under a contractual agreement with the Wisconsin Department of Health and Family Services, which is the oversight agency for LTC services and also the Medicaid agency. The CMO will be responsible for offering an array of LTC services to all persons living in its service area who meet functional level of care and financial eligibility criteria for such services.

Under the prepaid system, the CMO, a county-based system of care and services, will be able to use its existing local support systems, upon which people who are elderly or disabled rely, to promote better outcomes and improve system management. The Family Care waiver will allow CMOs to employ managed care strategies, such as care coordination, health promotion, quality improvement, and utilization management to a broader array of services than the home and community based waiver services. Wisconsin believes that this new set of tools, applied appropriately, will contribute to an improved service system and play a role in achieving valued outcomes for individuals.

Attachments: Wisconsin Administrative Code Chapter HFS 10 Family Care
Chapter 19.59 Wisconsin Statutes
Protecting against Conflict of Interest, packet presented to HCFA 11/9/00